# Frail older people given more choice and control in Hertfordshire

Herts Valleys CCG and East and North Herts CCG, in partnership with Hertfordshire County Council, completed a five month pilot to test how a more integrated, personalised approach could benefit older people with multiple long term conditions within their locality with startling results including 34 people now with a personalised care and support plan and 108 people having a frailty review.

**To start they set up three multidisciplinary front line teams in three different localities. Each team was sponsored by leaders across the health and social care system and the aim was to coordinate their delivery better; increase their community capacity; as well as implement personalised care and support plans and personal health budgets.**

The teams were based in St Albans, Herford and Hoddesdon, and focused on people over 65 years old with multiple physical health or mental health conditions or who identified as frail and living in their own homes. Over 600 people were offered a place to participate.

The teams were made up of over 30 multidisciplinary front line workers, including GPs, carers and people with lived experience, who all worked towards a common goal.

Initially the majority of team members had little understanding of personal health budgets and the importance of personalised care and support planning. By giving the teams ownership of the tools for personalised care and support planning and the 'permission' to work in an integrated way, their culture changed to one of cohesiveness and solution focused (as opposed to focusing on barriers and time constraints).

And results bear this out – with over 34 new personalised care and support plans completed; six new personal health budgets offered; 108 joined up frailty reviews completed and 51 people connected to community support. There were also some indications that this approach could help reduce the amount of admissions and length of stay to A&E, helping to ease winter pressures and beyond, and more work in being done to examine this effect.

But what did this mean for people? Examples of improved outcomes include a person who used a personal health budget to purchase a voice controlled speaker system which increased her self-management of appointments and medication reminders and reduced the workload of her informal carer and the community nurses.

Another example is a physiotherapist discussing 'end of life' planning with a patient on her caseload. This is not a new area of discussion for the therapist but this time the conversation was part of a support plan and was shared with the GP who then logged the decisions on the system, providing comfort to the patient that her wishes were recorded and in turn meant professionals didn't need to have this discussion.

A further output from the teams was recognition that one of the difficulties of integrated working was that they had varied understanding of other people's roles and responsibilities. By creating a *local directory of professionals and services* the teams could speed up referral processes, reduce unnecessary referrals and build up the interpersonal relationships that are needed for integrated working. The legacy of the Pilot continues today and one immediate outcome is a collective of motivated, multidisciplinary champions of personalised funding and practice throughout the area.